Regence

Medical Policy Manual Behavioral Health, Policy No. 35

Substance Use Disorder

Effective: June 1, 2023

Next Review: May 2024
Last Review: May 2023

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

The Substance Use Disorder (SUD) Policy provides treatment and program expectations and describe criteria that are used in determining medical necessity.

MEDICAL POLICY CRITERIA

Notes: The American Society of Addiction Medicine (ASAM) Criteria Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition are utilized for substance use disorder treatment medical necessity determinations.[1, 2]

I. The following criteria are used when determining medical necessity for each Level of Care (LOC) - (See appendix A for ASAM criteria summary).

   A. Inpatient Detoxification: Admission, continued stay, and transfer/discharge criteria for ASAM Level 4.0 - Medically Managed Intensive Inpatient Services.

   B. Residential or Subacute Detoxification: Admission, continued stay, and transfer/discharge criteria for ASAM Level 3.7 - Medically Monitored Intensive Inpatient Services.

C. Residential Rehabilitation: Admission, continued stay, and transfer/discharge criteria for ASAM Level 3.5 - Clinically Managed High Intensity Residential Services.

D. Partial Hospitalization: Admission, continued stay, and transfer/discharge criteria for ASAM Level 2.5 Partial Hospitalization Services.

E. Intensive Outpatient: Admission, continued stay, and transfer/discharge criteria for ASAM Level 2.1 - Intensive Outpatient Services.

NOTE: A summary of the ASAM guidelines is provided in Appendix A: An introduction to the ASAM criteria for patients and families (Pages 1-9).

POLICY GUIDELINES

I All SUD programs are expected to meet the following requirements (A-I):

A Licensure: The facility is licensed by the appropriate state agency.

B Psychiatric Services:

1. Inpatient (IP), Residential (RTC), Partial Hospitalization (PHP): There is an expectation of evaluation by a psychiatrist, a licensed psychiatric nurse practitioner, a board-certified addictionologist, or physician assistant with formal practice agreement with a psychiatrist (when permitted by state laws). The physician, or physician extender will continue to be available throughout the program as medically indicated for face-to-face evaluations.

2. Intensive Outpatient Services (IOP): There is an expectation of evaluation by a psychiatrist, a licensed psychiatric nurse practitioner, a board-certified addictionologist, or physician assistant with formal practice agreement with a psychiatrist (when permitted by state laws) when clinically necessary. The physician, or physician extender will continue to be available throughout the program as medically indicated for face-to-face evaluations.

C Medication Assisted Treatment (MAT) needs to be available when medically appropriate.

1. MAT may be available within the program offered.

2. If MAT is not available within the program, referral for MAT and time coordination of care outside of the program must be available.

D Family therapy:

1. For Adults: Family treatment is encouraged when clinically appropriate. Family treatment is available to be provided at an appropriate frequency when clinically warranted.

2. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy. The family/support system assessment will be completed within five days of admission with the expectation that family is involved in treatment

decisions and discharge planning throughout the course of care. Family sessions will occur at least weekly or more often if clinically indicated.

E **Individual Therapy:** Treatment programming includes documentation of at least one individual counseling session per week or more as clinically indicated.

F **Laboratory Testing/Urinalysis Testing**: Drug screens and relevant lab tests are completed upon admission and as clinically indicated and are documented in the clinical record.

G **Daily Treatment Services**:

1. Programming consisting primarily of counseling and education about addiction-related and mental health problems.
2. Daily treatment services to manage acute symptoms of the patient's biomedical, substance use, or mental disorder.

H **Treatment Planning & Discharge Planning**: There is an expectation that upon admission, an individualized treatment plan and discharge plan is developed within a reasonable timeframe.

I **Staff at Facility**:

1. Are an interdisciplinary team consisting of appropriately credentialed addiction treatment professionals. These may include:
   a. Counselors
   b. Psychologists
   c. Social workers
   d. Addiction credentialed physicians
2. Some, if not all staff should have sufficient cross training to understand the signs and symptoms of mental disorders, and to understand and be able to explain the uses of psychotropic medications and their interactions related to substance use.
3. For adolescent programs, staff should be knowledgeable about adolescent development and experienced in engaging and working with adolescents.
4. Allied health professional staff, such as counselor aides or group living workers, on-site 24 hours a day or as required by licensing regulations. One or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day.

II **In addition to the above requirements, the following guidelines are specific to each level of care (LOC):**

A Inpatient Detox: The provider is one of the following (1-4):

1. An acute care general hospital
2. An acute psychiatric hospital or
3. A psychiatric unit within an acute care general hospital
4. A licensed addiction treatment specialty hospital with acute care medical and nursing staff.

B **Services provided**:

1. A psychiatric evaluation is available to assess the patient in person within 24 hours of admission and thereafter as medically necessary.

2. A comprehensive history and physical examination, performed by a physician, a nurse practitioner, or a physician assistant with a supervisory or collaborative agreement with a physician within 12 hours of admission.
3. Medical management by physicians, nurse practitioners or physician assistants with a supervisory or collaborative agreement with a physician 24 hours a day, primary nursing care and observation 24 hours a day, and professional counseling services 16 hours a day.
4. A comprehensive nursing assessment, conducted at the time of admission.
5. Physician approval of the admission.

C Residential Detoxification or Subacute Detoxification

1. Daily nursing care is available.
2. A psychiatric evaluation is available to assess the patient in person within 24 hours of admission and thereafter as medically necessary.
3. A physical examination, performed by a physician, a nurse practitioner, or a physician assistant within 24 hours of admission, or a review and update of an existing physical examination conducted no more than 7 days prior to admission is done within 24 hours of admission.

D Residential Rehabilitation

1. Daily nursing care is available.
2. Psychiatric evaluation is completed within 48 hours of admission. After the initial diagnostic evaluation, there is an expectation that the physician, or physician extender provides and documents monitoring and evaluation as indicated, but no less than weekly.

E Partial Hospitalization Services

1. Twenty (20) or more hours of clinically intensive programming per week.
2. Psychiatric evaluation is completed within 48 hours of admission. After the initial diagnostic evaluation, there is an expectation that the physician, or physician extender provides and documents monitoring and evaluation as indicated, but no less than weekly.

F Intensive Outpatient Services includes:

1. Minimum of 9 hours of structured programming per week for Adults.
2. Minimum of 6 hour of structured programming per week for Adolescents.
3. Psychiatric evaluation is available when clinically necessary.

LIST OF INFORMATION NEEDED FOR REVIEW

REQUIRED DOCUMENTATION:

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

Initial Request:

- Initial Request Form or Stepdown request form (for step downs requests at the same facility).

- Supporting clinical documentation if requested by staff. This is not always required but may be necessary and required if the clinical information received via the form is not adequate to determine medical necessity. Supporting clinical documentation may include:
  - Initial Psychiatric Evaluation/Intake Assessment
  - Nursing Assessment/ History & Physical (if available)
  - Any additional supporting clinical evidence, if available (example: letters from outpatient providers supporting this level of care) Preliminary Individualized Treatment Plan.

Continued Stay/Concurrent Review:

- Concurrent Request Form
  - Supporting clinical documentation if requested by staff. This is not always required but may be necessary and required if the clinical information received via the form is not adequate to determine medical necessity. Supporting clinical documentation may include:
    - Most recent psychiatric evaluation
    - MD Notes
    - Individual and family therapy notes
    - List of current medications
    - Individualized Treatment Plan/Progress Reports.

REFERENCES

1. Medicine ASoA. About the ASAM Criteria. [cited 02/07/2023]. 'Available from:' https://www.asam.org/asam-criteria/about-the-asam-criteria.
2. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies®, 2013, pp.

CODES

Codes	Number	Description
CPT	None	
HCPCS	None	
Revenue Codes	0126	Room and Board – semiprivate two bed (medical or general); Detoxification
	0906	Intensive Outpatient Services, Chemical Dependency
	0912	Partial Hospitalization - Less Intensive; Chemical Dependency
	0913	Partial Hospitalization – More Intensive; Chemical Dependency
	1002	Residential treatment – Chemical Dependency

Date of Origin: *2023*

An Introduction to The ASAM Criteria for Patients and Families

This document has been created to provide you information about how some of the decisions regarding your available treatment or service options may have been made. It can help you understand how *The ASAM Criteria* is used in treatment, and how professionals such as physicians, providers, and funders of care rely on it to determine what services will best match a patient's individual needs. It is not a clinical document and cannot be used to diagnose or identify care. The information provided in this document is intended to help you become an active participant in your own care, but should not be considered medical advice, nor is it comprehensive or definitive. For more information, consult a skilled, trained professional in substance use, mental health and/or other addictive disorders who uses *The ASAM Criteria* in their work.

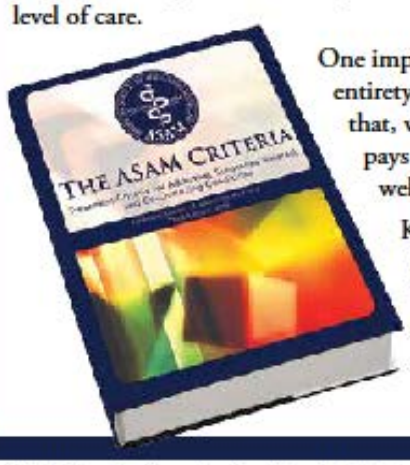
What is The ASAM Criteria?

The ASAM Criteria is a collection of objective guidelines that give clinicians a way to standardize treatment planning and where patients are placed in treatment, as well as how to provide continuing, integrated care and ongoing service planning. The criteria were developed by the American Society of Addiction Medicine (ASAM), and presented in a book written by a group of renowned doctors and professionals, working in a variety of mental health and addiction treatment fields. *The ASAM Criteria* has become the most widely used set of criteria in the United States for the treatment of substance-use issues, and it has been continually revised and updated over the years with the newest science in the field of addiction. Currently in its third edition (2013), *The ASAM Criteria* has been in use since 1991, and its foundations extend back even further into history.

"The least intensive, but safe, level of care..."

A "level of care" can refer to the intensity of treatment you might receive, such as the difference between a walk-in clinic and a 24-hour hospital stay. It is the goal of treatment providers to make sure the care you receive keeps you safe, and addresses all risks, but also that the care is as "least intensive," as possible, which helps you avoid unnecessary or wasteful treatment.

Treatment professionals use a lot of information to decide how to best provide care to their patients. They rely on clinical knowledge, their experience in the field, and, perhaps most importantly, the direction and goals developed collaboratively with the patient him or herself. Many professionals use *The ASAM Criteria* to assist them in filtering all of this knowledge and data, and in determining what kind of services can be provided to the patient at the least intensive, but safe, level of care.



One important aspect of *The ASAM Criteria* is that it views patients in their entirety, rather than a single medical or psychological condition. This means that, when determining service and care recommendations, *The ASAM Criteria* pays attention to the whole patient, including all of his or her life areas, as well as all risks, needs, strengths, and goals.

Keep in mind that *The ASAM Criteria* is an educational tool. It does not dictate a particular standard of care or specific treatment decisions. Treatment professionals are responsible for the care of their patients and must make independent judgments about whether and how to use *The ASAM Criteria* in their treatment decisions.

GUIDING PRINCIPLES OF THE ASAM CRITERIA

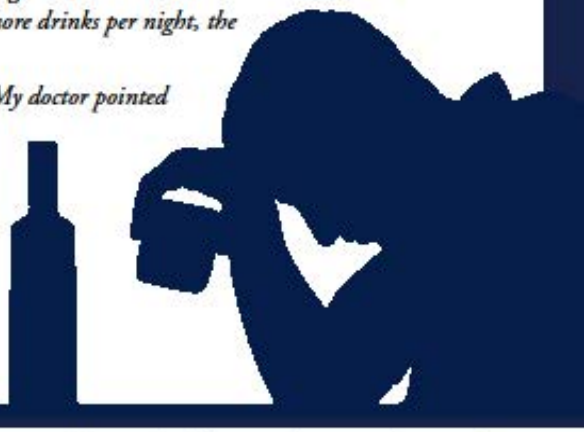
There are many principles that guided the development of *The ASAM Criteria*. Some of these principles can better explain the mindset of your physician or care provider, and help you understand how these criteria are used in determining the best treatment services for you.

- **Consider the whole person.** Rather than basing treatment decisions around a single element or diagnosis from your life, *The ASAM Criteria* takes a "multidimensional" approach, meaning it recognizes the many different areas of life that make up who you are, and how these life areas, or "dimensions," contain different risks and needs, as well as strengths and resources. A patient's risks, needs, strengths and resources provide the basis for creating a treatment plan.
- **Design treatment for the specific patient.** *The ASAM Criteria* recognizes that effective treatment cannot take a one-size-fits-all approach. Every individual's treatment plan is based on his or her unique needs, and therefore may be different, or require a variety of types or intensities of care.
- **Individualize treatment times.** Some programs use the same treatment timeline for all of their patients (such as putting everyone in a "28-day program"). *The ASAM Criteria* views treatment length as a unique factor—one that depends on the individual's progress and changing needs.
- **"Failure" is not a treatment prerequisite.** Some providers look at a patient's history to see if he or she has first "failed" out of less-intense services before approving a more intense type of care (such as a residential program or hospital stay). *The ASAM Criteria* does not see "failures" from treatment as an appropriate way to approve the correct level of care.
- **Provide a spectrum of services.** Although five broad levels of service are described in *The ASAM Criteria*, these levels represent benchmarks along a single continuum of care. These levels are linked to one another, and patients can move among and between them based on their current needs.
- **Reconceptualize the definition of "addiction."** In 2011, ASAM proposed a definition of "addiction" designed to be consistent with both clinical wisdom and the latest research discoveries. To read more, visit the following link: http://www.asam.org/for-the-public/definition-of-addiction.

At first, I couldn't understand why I was being sent to a residential center to address my alcohol use. I mean, it wasn't like I was drinking a bottle a day. I had thought the treatment decision would only be based on the average number of drinks I had: the more drinks per night, the greater the risk.

Turns out, the amount I was drinking was only part of the story. My doctor pointed out that some of my other health problems were not only quite serious, but actually related to my drinking. She saw other patterns I hadn't noticed, too: the stress from work that sent me to the bar, the repeated promises to quit, even some physical signs of withdrawal.

When my doctor made her treatment recommendation, she was looking at the "whole me," not just the amount of alcohol that was going in.



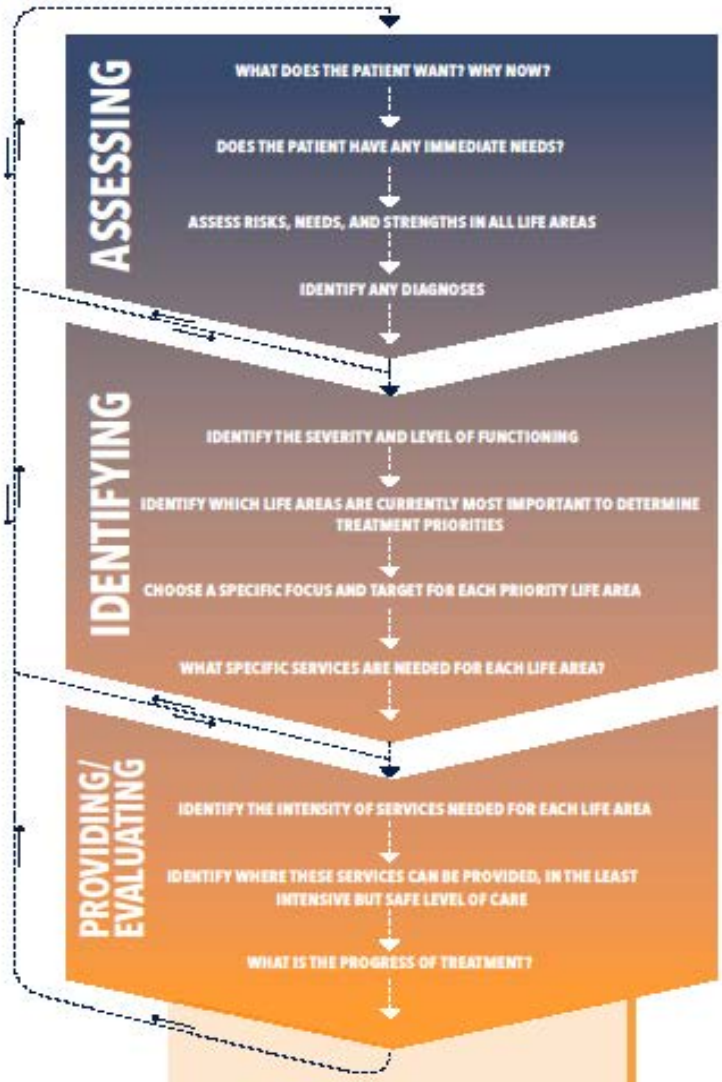
Using the Criteria to Make Decisions About Care

The ASAM Criteria provides treatment professionals with objective standards they can use to help identify the least intensive treatment services that can help keep a participant safe as he or she works to make personal life changes. But identifying the most appropriate services is just one step in a much more intricate process. *The ASAM Criteria* actually outlines a detailed flowchart that treatment providers and professionals can use to assist them in their clinical decisions.

This "decisional flowchart" has been provided here, and each of its three main components (Assessing, Identifying, and Providing/Evaluating) is discussed on the following pages.

These are steps providers and professionals work through together when discussing what type of care to offer—and fund—for an individual. Following this decisional flow helps ensure that treatment is being effectively managed, and that patients receive the appropriate intensity of care.

Why are they only seeing me twice a week? I'm having such a hard time with this. I should be in the hospital!



This decision-making chart shows how providers and funders of your care can create an overall treatment plan with the help of *The ASAM Criteria*. Take a look at what happens in each step. The patient is an active member throughout the process.

"ASSESSING" WITH THE ASAM CRITERIA

The "assessment" phase of treatment represents the early information-gathering phase, in which patient and physician work together to determine what signs and symptoms are present, and what they point to. *The ASAM Criteria* begins this phase by asking "What does the patient want?" and "Why now?" If there isn't good agreement and understanding on these early questions, it can significantly impact the later stages of treatment.

The ASAM Criteria is also unique in how it guides treatment professionals to conduct assessments. Rather than simply focusing on a diagnosis, or an isolated symptom, *The ASAM Criteria* uses what's called a "multidimensional" assessment. This assessment is a way to see how treatment might affect multiple life areas of an individual.

There are six major life areas (or "dimensions") detailed in *The ASAM Criteria*, and each one influences the others. Your treatment providers look at these dimensions from every angle, considering them separately and together, and exploring both risks and strengths in each.

Physicians use their clinical knowledge to gather information about these dimensions, and combine this with any other diagnoses (such as a substance use disorder) to complete the "Assessing" phase. (Some levels of care require that a patient have a specific diagnosis in order to be admitted. *The ASAM Criteria* specifies that a professional can use a reference tool such as the *DSM-5* or *ICD-10* in order to help determine a diagnosis.)

Here are the six dimensions of *The ASAM Criteria*, with a brief description of each one. Think of each dimension like the side of a cube, showing something different about who you are, and an essential part to what makes you, you.

1 Dimension 1: Acute Intoxication and/or Withdrawal Potential

This life area explores your past and current experiences of substance use and withdrawal.

2 Dimension 2: Biomedical Conditions/Complications

In this life area, think about your physical health, medical problems and physical activity and nutrition.

3 Dimension 3: Emotional/Behavioral/ Cognitive Conditions and Complications

This life area helps explore your thoughts, emotions and mental health issues.

4 Dimension 4: Readiness to Change

This life area identifies what you are motivated for and your readiness and interest in changing.

5 Dimension 5: Relapse/Continued Use/ Continued Problem Potential

This life area addresses concerns you might have about your continued substance use, mental health or a relapse.

6 Dimension 6: Recovery Environment

This life area explores your living situation and the people, places and things that are important to you.

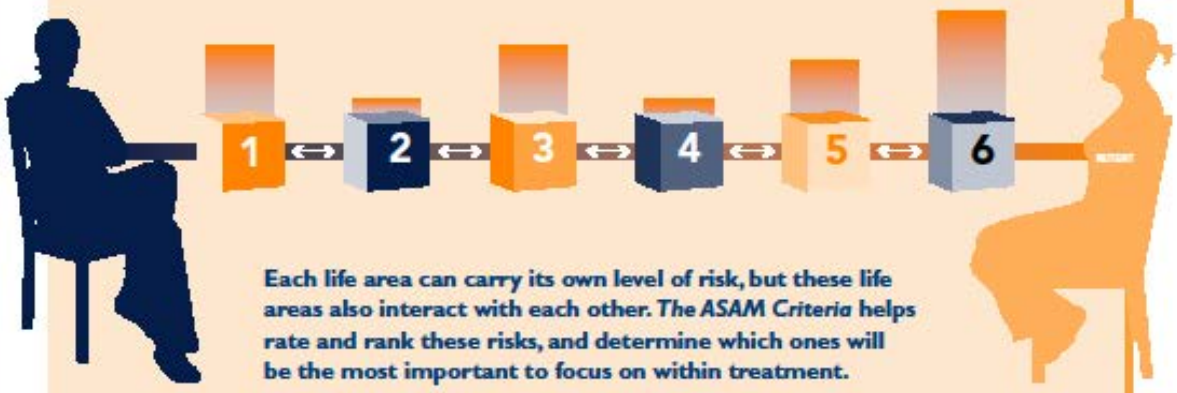
"IDENTIFYING" WITH THE ASAM CRITERIA

Once the information about a patient's wants, immediate needs, and different life areas have been gathered, treatment professionals move into the second phase of the decision-making process. This phase helps them identify what issues are of the highest severity, and of the highest priority, to address in treatment.

Treatment professionals rely on their clinical knowledge and training to help determine which issues and which life areas pose the biggest challenges. *The ASAM Criteria* helps them rank these areas and choose which ones to target during treatment. From here, professionals and providers can work with the patient to figure out the specific services needed, and what goals to set. No services are recommended that do not refer back to the patient's needs and goals.

I don't have a lot of support people in my life, and my living situation isn't very healthy right now, so I can understand being at a high risk in that particular area. What I didn't notice is that my personal motivation and my physical health are the strongest they've ever been. And those strengths can actually lower my overall risk.

So it turns out my treatment plan includes a lot of goals about finding a better place to live—one that supports the other healthy areas of my life. The type of care I receive is determined by my risks, but also by my strengths.



Each life area can carry its own level of risk, but these life areas also interact with each other. *The ASAM Criteria* helps rate and rank these risks, and determine which ones will be the most important to focus on within treatment.

"Providing/Evaluating" with The ASAM Criteria

The final phase of *The ASAM Criteria* treatment process takes the assessment information, and the identified priorities and services, and establishes what *intensity* of services should be provided. In other words, this is where service providers and patients decide how much (and how often) treatment is needed. Patients may require weekly, daily, or even hourly services (which might require a residential program or hospital stay). Again, this intensity is determined by a patient's unique, individual needs, and provided in the least intensive, but safe treatment setting. Once this has been done, the final step is to track the progress of treatment, including any recommendations for discharge, transfer, or continuing service

Discharge, Transfer, and Continuing Service

All decisions about when to end services, when to change services, and when to continue services are based on the progress the patient is making. *The ASAM Criteria* does not support any treatment that has dates of "graduation" or "completion" that can be assigned before treatment has even begun. The length of treatment depends upon the progress made, in clearly defined and agreed-upon goals, rather than a result of a program's preset structure.

When to Discharge from Treatment

When the patient has fulfilled the goals of the treatment services and no other service is necessary.

When to Transfer

There are many reasons a patient may be transferred to a different type of service. Two common ones are...

1. The patient is not able to achieve the goals of their treatment, but could achieve their goals with a different type of treatment.
2. The patient has achieved their original treatment goals, but they have developed new treatment challenges that can be achieved in a different type of treatment.

When to Continue Service

When the patient is making progress toward their goals, and it is reasonable to believe they will continue making progress with their existing treatment, it is appropriate to continue service.

The following pages include a condensed description of different "levels of care" a patient might be provided (such as an "outpatient clinic" or a "24-hour care" environment). These pages also include more detailed charts that illustrate a small part of the decision-making that providers and professionals can use to help them determine an appropriate level of care (including how the severity of different dimensions can point to different levels of care).

Levels of Care: Adolescents and Adults

Though the intensity of treatment is often split into "levels" of care, these levels connect to each other, acting more like "benchmarks" along a single spectrum. Patients can move between levels, depending on their unique needs. ASAM also uses separate criteria and levels of care benchmarks for adult patients and adolescent patients. This is because adolescents can be in different stages of emotional, mental, physical, and social development than adults. For this reason, certain adolescent services, such as withdrawal management, are bundled together with the rest of their treatment, whereas adults are able to enter into withdrawal management treatment separately.

Benchmark Levels of Care for Adolescents and Adults

Level of Care	Adolescent Title	Adult Title	Description
0.5	Early Intervention		Assessment and education
OTP (Level 1)	*Not specified for adolescents	Opioid Treatment Program	Daily or several times weekly opioid medication and counseling available
1	Outpatient Services		Adult: Less than 9 hours of service per week Adolescent: Less than 6 hours of service per week
2.1	Intensive Outpatient Services		Adult: More than 9 hours of service per week Adolescent: More than 6 hours of service per week
2.5	Partial Hospitalization Services		20 or more hours of service per week
3.1	Clinically Managed Low-intensity Residential Services		24-hour structure with available personnel, at least 5 hours of clinical service per week
3.3	*Not available because all adolescent levels attend to cognitive/ other impairments	Clinically Managed Population-specific High-intensity Residential Services	24-hour care with trained counselors, less intense environment and treatment for those with cognitive and other impairments
3.5	Clinically Managed Medium-intensity Residential Services	Clinically Managed High-intensity Residential Services	24-hour care with trained counselors
3.7	Medically Monitored High-intensity Inpatient Services	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability, 16 hour per day counselor availability
4	Medically Managed Intensive Inpatient Services		24-hour nursing care and daily physician care, counseling available

Benchmark Withdrawal Management Levels of Care for Adults

Level of Withdrawal Management for Adults	Level	Description
Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)	1-WM	Mild withdrawal
Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)	2-WM	Moderate withdrawal
Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)	3.2-WM	Moderate withdrawal requiring 24-hour support
Medically Monitored Inpatient Withdrawal Management	3.7-WM	Severe withdrawal requiring 24-hour nursing care, physician visits as needed
Medically Managed Intensive Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits

The following information cannot be used as a distillation of the full principles, concepts and processes within *The ASAM Criteria*. Many elements of a clinical decision are extremely abbreviated here and many parts of the decision-making process have been excluded for ease of patient understanding. This is not a clinical document.

Example Chart for Adult Levels of Care

Level of Care	Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5	Dimension 6
Level 0.5	No withdrawal risk	None, or stable	None, or stable	Willing to explore how use affects personal goals	Needs understanding or skills to change current use or high-risk behavior	Environment increases risk of use
OTP - Level 1	Physiological dependence needing OTP	None, or manageable	None, or manageable	Ready to change, but not ready for total abstinence	At risk of continued use without OTP	Supportive environment, patient has coping skills
Level 1	No significant withdrawal, minimal risk of severe withdrawal	None, or stable	None, or stable	Ready for recovery, needs strategies to strengthen readiness	Able to maintain abstinence or control use with minimal support	Supportive environment, patient has coping skills
Level 2.1	Minimal risk of severe withdrawal	None, or not distracting	Mild severity	Variable treatment engagement, requires structured program	High likelihood of relapse without close monitoring and support	Unsupportive environment, patient has coping skills
Level 2.5	Moderate risk of severe withdrawal	None, or not distracting	Mild to moderate severity	Poor treatment engagement, needs near-daily structured program	High likelihood of relapse without near-daily monitoring and support	Unsupportive environment, cope with structure and support
Level 3.1	No withdrawal risk, or minimal or stable withdrawal	None, or stable	None or minimal	Open to recovery, needs structured environment	Understands relapse, needs structure	Dangerous environment, 24-hour structure needed
Level 3.3	Minimal risk of severe withdrawal, manageable withdrawal	None, or stable	Mild to moderate	Needs interventions to engage and stay in treatment	Needs intervention to prevent relapse	Dangerous environment, 24-structure needed
Level 3.5	Minimal severe withdrawal risk, manageable withdrawal	None, or stable	24-hour setting for stabilization	Has significant difficulty with treatment, with negative consequences	Needs skills to prevent continued use	Dangerous environment, highly structured 24-hour setting needed
Level 3.7	High withdrawal risk, manageable withdrawal risk	Requires 24-hour medical monitoring	Moderate severity, requires 24-hour structured setting	Low interest in treatment, needs motivational strategies in 24-hour structured setting	Challenges controlling use at less intensive care levels	Dangerous environment
Level 4	High withdrawal risk requiring full hospital resources	Requires 24-hour medical and nursing care, requiring hospital resources	Severe or unstable challenges	Challenges here do not grant admission	Challenges here do not grant admission	Challenges here do not grant admission

The following information cannot be used as a distillation of the full principles, concepts and processes within *The ASAM Criteria*. Many elements of a clinical decision are extremely abbreviated here and many parts of the decision-making process have been excluded for ease of patient understanding. This is not a clinical document.

Example Chart for Adolescent Levels of Care

Level of Care	Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5	Dimension 6
Level 0.5	No withdrawal risk	None, or stable	None, or very stable	Willing to explore how use affects personal goals	Needs understanding or skills to change current use or high-risk behavior	Environment includes people with high-risk behaviors
Level 1	No withdrawal risk	None, or stable	No risk of harm	Willing to engage in treatment, needs motivating and monitoring strategies	Able to maintain abstinence or control use with minimal support	Environment supportive with limited assistance
Level 2.1	Minimal withdrawal, or at risk of withdrawal	None, or stable, not distracting	Low risk of harm, safe between sessions	Needs close monitoring and support several times a week	High risk of relapse, needs close monitoring and support	Needs close monitoring and support
Level 2.5	Mild withdrawal, or at risk of withdrawal	None, or stable, not distracting	Low risk of harm, safe overnight	Requires near-daily structured program to promote progress	High risk of relapse, needs near-daily monitoring and support	Needs near-daily monitoring and support
Level 3.1	Withdrawal or risk of withdrawal managed at another level	None, or stable, receiving medical monitoring	Need stable living environment	Open to recovery, needs limited 24-hour supervision	Understands relapse potential, needs supervision	Needs alternative secure housing placement or support
Level 3.5	Mild to moderate withdrawal, or at risk, not requiring frequent management/monitoring	None, or stable, receiving medical monitoring	Medium-intensity 24-hour monitoring or treatment	Needs intensive motivating strategies in 24-hour structured program	Needs 24-hour structured program	Needs residential treatment to promote recovery
Level 3.7	Moderate to severe withdrawal, or at risk	Requires 24-hour medical monitoring	High-intensity 24-hour monitoring or treatment	Needs motivating strategies in 24-hour medically monitored program	Needs high-intensity 24-hour interventions	Needs residential treatment to promote recovery
Level 4	Severe withdrawal, or at risk, requiring intensive active medical management	Requires 24-hour medical and nursing care, requiring hospital resources	Severe risk of harm	Challenges here do not grant admission	Challenges here do not grant admission	Challenges here do not grant admission